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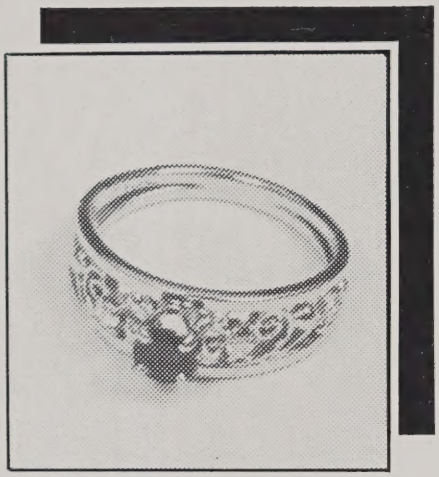

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THE HAMPDEN HIPPOCRAT

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OCTOBER — NOVEMBER 1986

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THE HAMPDEN HIPPOCRAT

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OCTOBER — NOVEMBER 1986

VOLUME XXXXII NO. 12

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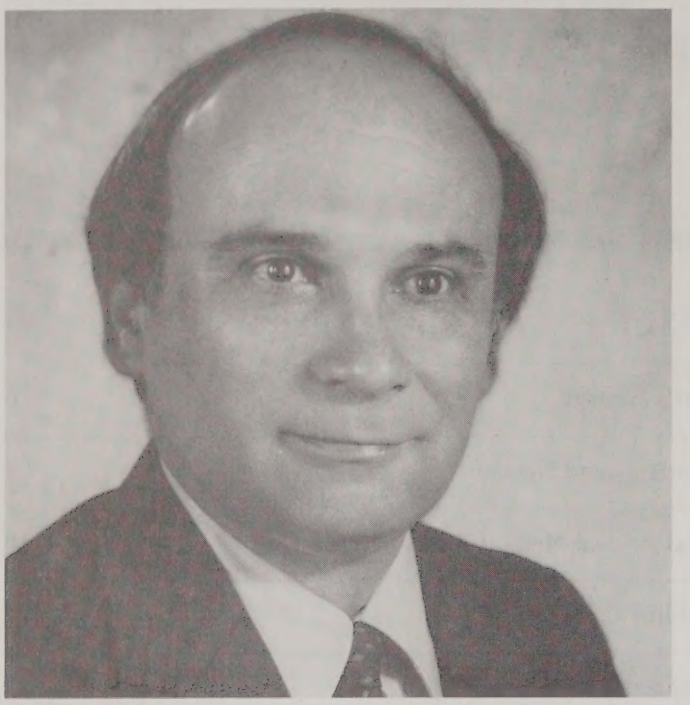
HDMS President's Message

"Off the Top of My Head"



Gregory A. Slachta, M.D.

How should the elderly look at HMO's? Says Helen Savage, Director of AARP's HMO Informed Buyer Project in Modern Maturity, (Oct.-Nov. '86),"People should take a hard look at HMOs before signing up...In general, relatively few HMOs have tailored their health-care delivery system to the needs of older people...Even many of those with Medicare contracts have not added staff with skills in geriatric medicine...Unfortunately, it appears that some HMOs protect their pocketbook by skimping on care." She goes on to say that some HMOs are apparently using dubious marketing practices in that they are seeking to enroll only healthy individuals, contrary to federal policy.

Because of this latter factor the Government Accounting Office has recommended that HMOs be reimbursed at lower than the 95% level because they are taking only the healthy elderly and costing the government more in caring for those who are really ill. (I believe the federal government may have discovered the principle of skimming).

Buy American? That's what American labor and industry is saying, particularly in the auto industry. Roger Smith, President of General Motors, says medical insurance costs too much and is cutting into his profits, so GM has gotten into the HMO business in Detroit. Lee Iacocca, President of Chrysler, tells us he can straighten out the Medicare situation and the Ford Motor Company entered our Blue Shield suit with an amicus (friend of the court) brief against us on balance billing in Massachusetts. [need I say more?]. The AFL-CIO is a major force against us as well and contributed to Master Health Plus.

Speaking of Blue Shield, John Larkin Thompson has told us we can end the non-participating (lock-out) clause of our contract by supporting the Blue Cross-Blue Shield Merger Bill. Legal evaluation of this bill indicates that the language is very vague and not guaranteed in the bill. [Nice smoke screen, John]...By the way, Mass. Mutual testified at the Public Hearing of the Study Commission on Health Care Financing and Delivery Reform to end the non-participating agreement (as well as other special Blue Cross-Blue Shield marketing advantages). It seems that deregulation has brought prices down in every industry in which it has been tried, but the government is unwilling to do it in medicine, probably because the legislature already has a non-par agreement for itself.

I understand John Larkin still believes there are too many doctors in the Commonwealth and they make too much anyway. I'm told John makes over $200,000 a year so he should be able to travel to New York or Philadelphia to find a doctor next year when the new malpractice rates come out.

Did you know it appears that a new physician coming into the State of Massachusetts will be responsible for the retroactive premiums from 1983 to date. [That should do wonders in recruiting new physicians. The legislature may have to enact a law to prevent residents from leaving the state.]

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There is an obvious conflict between Utilization Review and Quality Assurance in the hospital setting. Now that risk sharing (a misnomer for DRG's) has set in, it appears that hospitals do not want sick patients. Hopefully, they will not use their Physician Practice Profiles that monitor cost (to the hospital) not efficiency of the physician or quality of the care (they say it does) as a ruler for staff privileges. We as a District will monitor it closely. Only physicians can be true advocates of quality care for our patients. The District and the AMA have a clearinghouse for abuses to the care of the elderly. This should incude inadequate nursing care and inability for discharge because of inadequate facilities being available. We must monitor this as physicians and urge you to communicate to us and participate in this national monitoring program. By the way, the Mass. Hospital Association's position that failure of the DRG program comes down to the need for physician education to bring down the length of stays is inappropriate. Remember, you bear the responsibility for malpractice if the patient was discharged too soon and are being monitored for your readmission rates by the federal government. Recently, an Indiana study has demonstrated that the outpatient care of diabetics has lead to higher cost than regulating them in the hospital and was detrimental to quality care.

Will risk sharing (shifting) work? Not a prayer. The Medicare system part A will be in the red by 1990 and the whole system will have a deficit of one trillion dollars by 2010. Remember that that is with a freeze on physician fees of almost three years now. If we become indentured servants and made nothing, we could not save this system. [We can no longer rob Peter to pay Paul; we are running out of Peters.] The AMA has a very workable program to replace Medicare that requires pre-funding the health care for future generations. The Ponzi Scheme must end or there will be wholesale rationing of care for the elderly.

Finally, a special thanks to our local hospitals and businesses who supported us at our recent District meeting with nationally known columnist Mark Shields. To our physicians who attended and supported this major up-grade of the Society, a very special thank you to you. To the rest of the physicians who are not yet ready for prime time, I assure you, there is no free lunch.

"Obstacles are those frightful things you see when you take your eyes off your goals."

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Liberty, Independence and Freedom

Guenter L. Spanknebel, M.D.

I wish I were a gifted poet or at least a Presidential speech writer in order to convey to you my intense emotions which I experienced on two recent occasions, the Annual Meeting of the House of Delegates of the American Medical Association and the very special 1986 Independence Day celebration. To me, these seemingly diverse events actually shared the same basic principles; each transmitted the same powerful message that all, but especially the medical profession, must hear and act upon.

Let me briefly highlight the event that did not attract the attention of the media: the meeting of the AMA House of Delegates in Chicago. 391 Delegates were seated representing state medical associations, national medical specialty societies, special sections for medical students, residents, medical schools, hospital medical staffs, and the service delegates from the Army, Navy, Air Force, Public Health Service and Veterans Administration. Now add to this already formidable group an equal number of alternate delegates, officers, trustees, members of task forces, councils and advisory committees, individual AMA members who wished to testify at hearings, volunteers, guests, the AMA staff who saw to it that this complex meeting ran smoothly and productively and, indeed, you have an impressive gathering. Consider not only its size, but the enormous wealth of talent, knowledge and unselfish dedication to medicine inherent in the group! Understand that most of these participants gave up at least five days of their time away from home, family, patients, and, yes, from income-producing activities! In return for what, you might ask. My own response is: "for the opportunity to participate in the democratic process of discussion and decision-making, and with my one vote, help to shape the health care of my patients and guide the ethics and conduct of our profession."

I wish each and every one of you could have experienced the spirit and enthusiasm which prevailed at the meeting of the House as, for example, when grappling with such vital issues as financing quality health care for the elderly and adopting a proposal to replace Medicare with a pre-funded, fiscally-sound, innovative program offering comprehensive protection, catastrophic coverage, free choice among competing health plans and access to quality care. This spirit and enthusiasm was evident when dealing with the complexities of the final report of the AMA Task Force on Physician Manpower and its recommendations for ongoing analysis of manpower issues, physician supply and its impact on quality and cost of care, planning first-year enrollments and monitoring their relationship to educational program quality, policies on reasonable quality standards in the practice of medicine, consideration of accreditation criteria for foreign medical schools, improving geographic and specialty distribution of physicians and enrolling and retaining under-represented groups in United States schools, or when deliberating and adopting the Council on Medical Services' report on a definition, finally, of what constitutes "QUALITY CARE" and how to monitor it. Also, alcohol advertising directed at youth and so many other "pro bono issues", i.e. smoking, boxing, seat belts, dietary habits and infection control were heatedly discussed and translated into sound proposals for action--a sheer endless list of concerns for the health and welfare of all.

I wish you could have been present during the discussions on the professional liability and insurance crisis. The mixed emotions which pervaded the profession nationwide ranged from frustration and disbelief to plain outrage. Even when dealing with volatile issues threatening the very existence of our society, the medical profession showed restraint and worked on proposals promising to be in the best interest of the individual citizen as well as the nation as a whole, e.g., tort reform alternatives, coalition-forming with other segments of society equally threatened by liability problems, improved risk management, peer review, self-policing and disseminating information on legal challenges to tort reforms in other states to state medical associations.

And then, you should have also seen the efforts that went into strengthening representation and active involvement in organized medicine of young physicians by establishing a Young Physician Section with a voting delegate.

The second event shouldn't need to be described here, as we all lived through the excitement, pomp, speeches, cookouts and fireworks of the glorious Fourth—or at least watched some of the display on TV.

What message did both events have in common that we in the medical profession should hear and act upon? Does it take the sensitive ear of one who came ashore at the feet of Lady Liberty (many years ago) to hear the message..."all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life,

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Liberty and the Pursuit of Happiness."

Do we always remember *what happiness* we physicians originally set out to pursue? Or, for that matter, do we care to know what happiness other segments of our society seek? Happiness is, for a physician, a happy patient. One who enjoys health as long as possible, suffers little or no pain, and when the time comes, dies an easy death. Let us pursue our personal and professional happiness with vigor and let others pursue theirs. Let us not be know-it-alls and do-it-alls in extra medical affairs. Let us not meddle in politics and power, but seek out capable and responsible public servants dedicated to work "for the people," whose happiness may be a happy voter. Or even better, let them seek us out for being trustees for many happy patients and potential happy voters. Let us not "chase the buck", thereby wasting precious time by dabbling in stocks, real estate and economic indices, but leave these activities to experts whose happiness may be "making a bundle" for themselves and their happy investors. Let us never legislate or interpret legislation by other than setting an example of how to act as a profession which implies setting aside self interest in favor of the happiness of those we serve, which may indeed be the happiness the legal profession pursues.

Not only does it take a sensitive ear to hear the message, it takes courage to act on the strength of our convictions..."that, to secure these rights, Governments are instituted among men, deriving their just Powers from the consent of the governed."

Herein lies the key to liberty, independence and freedom! We must rededicate ourselves to the pursuit of our happiness on a one-to-one relationship with the patient and we must participate in the most perfect democratic process offered by our professional association, the AMA, to secure this basic right, to provide leadership and at the same time to fulfill our professional obligations to society.

Dr. Spanknebel, President of the Worcester District Medical Society graciously granted permission for publication of this article.

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Report of Second Annual Medical Ethics Seminar

The Second Annual Medical Ethics Forum Seminar was held on Wednesday, September 17, 1986 at the Chapin Auditorium of Springfield Municipal Hospital. Thomas A. Shannon, Professor of Social Ethics and Religion, and Ruth L. Smith, Assistant Professor of Religion, Department of Humaniites, Worcester Polytechnic Institute were the principal speakers.

The main topic discussed was the dilemma of withholding or withdrawing nutritional support to a patient who would be described as in a persistent vegetative state. Professor Shannon discussed the ethical issues involved in giving nutritional feeding to such a patient and the ethical reasons why some people would be in favor of terminating feeding. Professor Smith likewise discussed the issue in similar patients and why one could not ethically terminate feeding. It was most apparent that an important balance was provided by the speakers being a man and a woman.

Following the normal presentations a sample case, basically the Brophy Case, was presented for group discussion to the audience. A panel consisting of Professors Shannon and Smith, Attorney Brown and Father John Tuohey fielded questions from the floor regarding the many medical, social, philosophical and legal aspects of allowing a patient to die by withholding nutritional feeding.

The Seminar audience of approximately 180 people was grateful for the opportunity to hear and discuss this most difficult medical ethical dilemma. It was most apparent that collective thought and dialogue from all disciplines is needed to give constructive consensus. This constructive consensus that values man's responsibility and role of when to support a person's life is so needed in our present day state of medical care.

Our committee is sincerely grateful for the energetic, enthusiastic assistance provided by Carol Nystrom, Executive Secretary, and Carol Sarno, her associate. The success of the meeting was very much a measure of their dedication. We also wish to thank all the other willing volunteers who gave assistance during the evening.

The Seminar was sponsored by the Hampden District Medical Society and its Springfield Academy of Medicine.

James G. Fitzpatrick, M.D. Chairman
Medico-Religious Committee

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The Medical Liability Crisis:

Its Causes—and Pathways to Solutions

For months it's been difficult to read about trends in the insurance industry—especially medical malpractice insurance—without seeing the word "crisis". That can be risky in a nation where language is so easily trivilized, where "crisis to crisis," and world troublespots endure a succession of "crises."

But to a physician who has received notice of another increase in his or her medical liability insurance premium, or an obstetrics patient whose physician has quit delivering babies, or the lawmaker hearing conflicting recommendations on what is needed to improve our civil justice system—the "medical liability crisis" is very real. It is an issue that touches doctors, patients, attorneys, insurers and legislators across the nation.

More importantly, it is a crisis that can only be solved through concerted efforts by all invloved.

Thrust into this issue is St. Paul Fire and Marine Insurance Company, one of The St. Paul Companies, Inc., or "The St. Paul." With over 17 percent of the medical liability premium volume in the nation—insuring more than 50,000 physicians and surgeons, 1,550 hospitals and hundreds of other professionals, practices and institutions—The St. Paul is the leading writer of medical malpractice in the nation. The remainder of the market is spread among a varied mix of private and not-for-profit insurers. Sixty percent of that market, in fact, is held by mutual insurers, owned, operated or sponsored by health care professionals.

(The St. Paul does not underwrite physicians in Massachusetts, site of a joint underwriting association, or JUA. In Massachusetts The St. Paul is employed to service the JUA, performing claim adjustment, risk management and administrative services. The St. Paul underwrites physician medical liability business in 43 other states).

What caused the current crisis in medical liability, and what remedies are needed? With 50 years' experience in medical liability insurance The St. Paul stands as a unique consultant to society in its search for solutions. More immediately, in an issue marked by fingerpointing, oversimplifications, and, often, more "heat" than "light", that experience can help resolve this complex and difficult problem facing our society.

When The St. Paul began writing medical liability coverage in the 1930's, malpractice insurance was viewed as a relatively stable line of business. That stability evaporated in the 1970's. The St. Paul had witnessed a deterioration in its medical liability line in the late 1960's when an increasing number of claims were being filed years after the alleged malpractice incident. New mutual insurers and JUAs were formed in reponse.

The St. Paul did not leave the marketplace in the 1970s crunch. But it did pioneer the claims-made policy—which is quickly becoming the industry standard—during this trying period.

Claims-made policies cover claims reported while a policy is in force—regardless of when the service was rendered, so long as it occured after the date when the claims-made coverage was first begun. The other form of liability coverage is the occurrence policy, which covers all claims resulting from services rendered while the policy is in force, regardless of when claims are reported. Thus, the more accurate pricing of claims-made policies encourages continued market stability and availability. Furthermore, the claims-made policy allows doctors to adjust their coverage limits annually to meet the legal, social and economic climates of each year.

While the 1970s saw reduced availability in medical liability coverage, the 1980s have been a time of continued increases in premium rates, due to continued large increases in both the frequency and severity of malpractice claims. Over the past ten years the frequency of medical liability claims against St. Paul-insured physicians has jumped from 8.5 claims per 100 doctors, to 17.8 The average paid claim has skyrocketed from $16,900 in 1975 to $70,200 in 1985.

What, then, will stem this tide, and restore much-needed consistency and predictability to the system of medical liability? While no one can provide quick, definite answers, two important principles are helping to lead The St. Paul through the morass. First, there *are* no easy answers, and solutions will not necessarily come easily. Second, with our experience and expertise, we have sought to provide testimony, data and insights into the effects of the current crisis, to aid society's decisionmakers in their struggle toward solutions.

continued on next page

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The Medical Liability Crisis:

continued from previous page

The St. Paul has also undertaken in-depth analyses of closed claims within given specialties or procedures, and provides seminars, publications, risk management services and other programs of assistance to hospitals and health care professionals.

It is also important to note that The St. Paul is continuing to demonstrate its reputation for aggressive medical liability claims handling. We have increased, for example, our training for attorneys who handle malpractice defenses, conducting seminars to help them understand the medical aspects of cases, as well as legal defenses.

The medical liability crisis is wider, however, than any one insurer, institution or even one state can resolve. The first step toward that goal is to end the fingerpointing and blamelaying that has marked the issue from all sides, and to reject the oversimplifications on what has caused the crisis.

The real issues are:

- The frequency of claims
- The expense of moving those claims through the civil justice system, and
- The amounts of the recoveries.

The increases in the number and amounts of those recoveries are causing increases in premiums. Control of those recoveries is in the hands of those who set the rules of the civil justice system. Those rule-setters, administrators, facilitators and decisionmakers include legislators, judges, attorney and juries. The temptation is for legislators and regulators to search for a simple, painless way to answer demands for action to reform the system, while at the same time appeasing those who insist that nothing should be changed.

Because the St. Paul is a facilitator—and not a direct beneficiary—of the tort system, we reflect the costs of society's expectations and demands. Our proper role in the current debate is to reflect accurately the cost of the system that society detrermines is best. We have shared data in presentations to many legislative committees, showing the magnitude of losses and current trends in loss costs and the number of claims.

As information from a variety of sources is put forth, it is up to the citizens to select, through their elected representatives, the type and scope of their civil reparation system—who is to be paid, under what circumstances, and how much. *All* stakeholders must help determine which changes will be the most effective, and must become involved in the federal and state legislative processes.

During this process, the economic facts of availability and affordability of liability insurance must be kept in mind. Loss costs are what drive insurance prices: as loss costs continue to climb, the cost of insurance rises in response.

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YEAR	FREQUENCY*	AVERAGE PAID CLAIM**
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1977	7.6	$19,000
1978	8.5	$24,000
1979	8.9	$24,400
1980	10.6	$28,100
1981	11.4	$36,800
1982	13.3	$45,400
1983	15.1	$53,400
1984	16.5	$56.700
1985	17.8	$70,200

* Frequency is the number of claims per 100 physicians.
** Payment made to plaintiff.

Editor's Note—

The above article was kindly submitted by Mr. Diedrich upon our solicitation.

If you have any specific questions or issues you wish Mr. Diedrich to address, please submit them to the Editors and we will pass them along for a future article.

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In Pursuit of Mediocrity

(UP-New York) Herman J. Flurd was 48 years old when he lost his second fortune. A boy wonder entrepreneur, he had founded a highly successful computer software company in his parent's garage when he was 16. *Software For Pets* rapidly expanded from a one-man part time operation to a firm employing 200 individuals, and thinking about diversification. One of their products, in fact, had become the leading Software product in the year it was released. "Sandbox City" was an attractive program designed to teach kittens to use a sandbox for their excretory needs; once the animal has learned to press the keys on the keyboard of the home computer, it took about an hour for the animal to progress to a point where it could use the sandbox routinely. Another product taught canaries to sing; a third taught dogs to roll over and play dead. Flurd recognized that, despite the current boom, sooner or later his company would face stiffer competition. He decided to arrange a seminar for his employess entitled "In Search of Excellence" with the intention of acquainting them with the principles of efficiency, better time management, and goal clarification.

One year after this event, *Software for Pets* had become a multinational conglomerate, acquiring Olivetti of Italy, Mitsubishi of Japan, and deBeers of South Africa. The management force had become so large that the country of Luxembourg had to be rented for the annual sales meetings. The gross output of *Software for Pets* was now greater than all but three countries; the income was second only to that of General Motors.

But Flurd was not part of it. He had been ousted in a complex leveraged buyout takeover restructuring tax deferrment move by his middle management, which purchased his $15,000,000,000 equity in the company for $4.98, and created an entirely new area of corporate law.

Not daunted, he picked himself up and set out to climb to the top again. In short order he applied his imagination and perserverence to the problem of higher education. He reasoned that college education had become entirely too expensive; and that in addition, just about everyone had a college education these days; and finally that there were very few jobs which you really needed a college education for. The answer was a quality diploma mill. He founded the "University of South Wyoming" which was actually operated out of his parent's garage. The demand for diplomas was remarkable, and soon he was employing 500 individuals and had moved to a former rubber wrench factory. Preparing for even greater future growth, he made his employees attend seminars in "One Minute Management", "Theory Z", and similar programs. His company thrived, buying up General Motors and IBM with equity from each other, and preparing to take on AT&T and Xerox. But he was no longer part of it; he was again out on the street with 79 cents in his pocket.

continued on next page

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In Pursuit of Mediocrity

continued from previous page

Flurd withdrew to his parent's garage, and spent several months in seclusion. When he next emerged, he had a mission. He set out to discover what makes individuals and corporations mediocre. To develop his theories on mediocrity he interviewed thousands of mediocre individuals. He traveled throughout the entire United States to collect his data; he managed to interview hundreds of federal and state legislators, as well as thousands of government employees.

The result was the book, *In Pursuit of Mediocrity,* which this week achieved runaway bestsellerdom.

E. Findlay Smith-Caufield III, Chairman of the Board and Chief Executive Officer of Vito Vinzelli Industries, a leading firm in the manufacture and distribution of recreational drugs, remarks that the book has been a life-saver for his company.

"After we had the "Japanese Theory of Management" boys in, we were getting to the point where we had to return our middle management to their previous level of mediocrity, or alternatively, waste them, if we wanted to hold on to the company," he said. "But then we started implementing the principles of "In Pursuit of Mediocrity" and things have settled down again."

Flurd now heads a think-tank in Dubuque, Iowa, from which he continues to research mediocrity. He has developed a series of lectures and presentations for interested corporations. He summarily dismisses anyone who so much as suggests a seminar on better management or increasing human potential. He also investigates any prospective employees to make sure that they have never attended any sort of seminars along those lines.

"We see our efforts as a growth industry," said Flurd. "C.E.O.'s figure that their companies can make a lot more money if the employees are firmly committed to the company's success, and are allowed to exercise their creativity. But once that happens, the C.E.O. finds himself under a great deal of pressure from below. At that point, he realizes that what he really wants is his power and ability to make preemptory and irrational decisions. He realizes that he enjoyed playing God, and now that has been taken away from him. At that point, he is ripe for our services."

Darrell R. Finsterwood, a member of the Dogwood Institute, a prestigious economic think tank, points out that mediocrity is in fact economically defensible. "If everyone worked to their top capacity," he states, "there would be a remarkable heating up of the economy. Businesses and industries would have to expand the 24 hour days and 7 day weeks to accomodate the increased productivity. The world would be too small to absorb the increased output; prices would fall, making Cadillacs, for example, accessable to starving peasants in Bangladesh. Everyone would have everything he or she wanted, and at that point, the population of achievers would turn more and more of their energies into philanthropy, arts, and leisure. In short, if we eliminated mediocrity, we would eliminate scarcity; and if we eliminated scarcity, we would have no use for an economy; and if we had no use for an economy, there would be no use for economists, politicians, dictators, bankers, or lawyers.

Furd in fact had started a subsidiary organization to take the best of several management theories and market books, seminars, and consultations to corporations. His goal is to have every C.E.O., at one time during his/her tenure, hire his management company to improve productivity and employee satisfaction, and then hire his "In Search of Mediocrity" services to turn the employment force back into surly, uncaring nine-to-fivers.

With the rapid growth of Furd's new enterprise, one might expect a host of imitators. But Furd is unconcerned. "Teaching people how to be consistently mediocre," he points out, "is a lot harder than it sounds. The employee has to be able to completly surpress any impulse to exercise creativity on the job. He or she has to be on guard when other employees try to change things, and ruthlessly suppress those attempts. Perhaps the hardest thing to teach employees is that being mediocre is not just lack of excellence; it must be pursued with the same degree of effort. A quiet mediocre employee is one thing; but one who whines all the time will help his co-employees develop their own mediocrity."

Furd has a messianic vision. By the year 2000, he wants the entire American work force to be "mediocritized". "It isn't as great a task as it seems," he says, "I would estimate that we're about 90% there already."

"Anonymous"

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†CAPOTEN is indicated in patients with heart failure who have not responded adequately to or cannot be controlled by conventional diuretic and digitalis therapy. CAPOTEN is to be used with diuretics and digitalis. In using CAPOTEN, consideration should be given to the risk of neutropenia/agranulocytosis. Use special precautions in patients with impaired renal function, collagen vascular disorders, or those exposed to other drugs (e.g., procainamide) known to affect the white cells or immune response. Evaluation of heart failure patients should always include assessment of renal function. See INDICATIONS, WARNINGS, and ADVERSE REACTIONS in the brief summary on the adjacent page.

CAPOTEN® TABLETS
Captopril Tablets

INDICATIONS: Hypertension—CAPOTEN (captopril) is indicated for the treatment of hypertension. Consideration should be given to the risk of neutropenia/agranulocytosis (see WARNINGS). CAPOTEN may be used as initial therapy for patients with normal renal function, in whom the risk is relatively low. In patients with impaired renal function, particularly those with collagen vascular disease, captopril should be reserved for those who have either developed unacceptable side effects on other drugs, or have failed to respond satisfactorily to drug combinations. CAPOTEN is effective alone and in combination with other antihypertensive agents, especially thiazide-type diuretics.

Heart Failure: CAPOTEN (captopril) is indicated in patients with heart failure who have not responded adequately to or cannot be controlled by conventional diuretic and digitalis therapy. CAPOTEN is to be used with diuretics and digitalis.

WARNINGS: Neutropenia/Agranulocytosis—Neutropenia ($<1000/mm^3$) with myeloid hypoplasia has resulted from use of captopril. About half of the neutropenic patients developed systemic or oral cavity infections or other features of the syndrome of agranulocytosis. The risk of neutropenia is dependent on the clinical status of the patient:

In clinical trials in patients with hypertension who have normal renal function (serum creatinine <1.6 mg/dL and no collagen vascular disease), neutropenia has been seen in one patient out of over 8,600 exposed. In patients with some degree of renal failure (serum creatinine at least 1.6 mg/dL) but no collagen vascular disease, the risk in clinical trials was about 1 per 500. Doses were relatively high in these patients, particularly in view of their diminished renal function. In patients with collagen vascular diseases (e.g., systemic lupus erythematosus, scleroderma) and impaired renal function, neutropenia occurred in 3.7% of patients in clinical trials. While none of the over 750 patients in formal clinical trials of heart failure developed neutropenia, it has occurred during subsequent clinical experience. Of reported cases, about half had serum creatinine ≥ 1.6 mg/dL and more than 75% received procainamide. In heart failure, it appears that the same risk factors for neutropenia are present.

Neutropenia has appeared usually within 3 months after starting therapy, associated with myeloid hypoplasia and frequently accompanied by erythroid hypoplasia and decreased numbers of megakaryocytes (e.g., hypoplastic bone marrow and pancytopenia); anemia and thrombocytopenia were sometimes seen. Neutrophils generally returned to normal in about 2 weeks after captopril was discontinued, and serious infections were limited to clinically complex patients. About 13% of the cases of neutropenia have ended fatally, but almost all fatalities were in patients with serious illness, having collagen vascular disease, renal failure, heart failure or immunosuppressant therapy, or a combination of these complicating factors.

Evaluation of the hypertensive or heart failure patient should always include assessment of renal function. If captopril is used in patients with impaired renal function, white blood cell and differential counts should be evaluated prior to starting treatment and at approximately 2-week intervals for about 3 months, then periodically. In patients with collagen vascular disease or who are exposed to other drugs known to affect the white cells or immune response, particularly when there is impaired renal function, captopril should be used only after an assessment of benefit and risk, and then with caution. All patients treated with captopril should be told to report any signs of infection (e.g., sore throat, fever); if infection is suspected, perform counts without delay. Since discontinuation of captopril and other drugs has generally led to prompt return of the white count to normal, upon confirmation of neutropenia (neutrophil count $<1000/mm^3$) withdraw captopril and closely follow the patient's course.

Proteinuria—Total urinary proteins >1 g/day were seen in about 0.7% of patients on captopril. About 90% of affected patients had evidence of prior renal disease or received high doses (>150 mg/day), or both. The nephrotic syndrome occurred in about one-fifth of proteinuric patients. In most cases, proteinuria subsided or cleared within 6 months whether or not captopril was continued. The BUN and creatinine were seldom altered in proteinuric patients. Since most cases of proteinuria occurred by the 8th month of therapy, patients with prior renal disease or those receiving captopril at doses >150 mg/day should have urinary protein estimates (dip-stick on 1st morning urine) before therapy, and periodically thereafter.

Hypotension—Excessive hypotension was rarely seen in hypertensive patients but is a possibility in severely salt/volume-depleted persons such as those treated vigorously with diuretics (see PRECAUTIONS [Drug Interactions]).

In heart failure, where blood pressure was either normal or low, transient decreases in mean blood pressure $>20\%$ were recorded in about half of the patients. This transient hypotension may occur after any of the first several doses and is usually well tolerated, although rarely it has been associated with arrhythmia or conduction defects. A starting dose of 6.25 or 12.5 mg tid may minimize the hypotensive effect. Patients should be followed closely for the first 2 weeks of treatment and whenever the dose of captopril and/or diuretic is increased.

BECAUSE OF THE POTENTIAL FALL IN BLOOD PRESSURE IN THESE PATIENTS, THERAPY SHOULD BE STARTED UNDER VERY CLOSE MEDICAL SUPERVISION.

PRECAUTIONS: General: *Impaired Renal Function,* Hypertension—Some hypertensive patients with renal disease, particularly those with severe renal artery stenosis, have developed increases in BUN and serum creatinine. It may be necessary to reduce captopril dosage and/or discontinue diuretic. For some of these patients, normalization of blood pressure and maintenance of adequate renal perfusion may not be possible. Heart Failure—About 20% of patients develop stable elevations of BUN and serum creatinine $>20\%$ above normal or baseline upon long-term treatment. Less than 5% of patients, generally with severe preexisting renal disease, required discontinuation due to progressively increasing creatinine. See DOSAGE AND ADMINISTRATION, ADVERSE REACTIONS [Altered Laboratory Findings]. *Valvular Stenosis*—A theoretical concern, for risk of decreased coronary perfusion, has been noted regarding vasodilator treatment in patients with aortic stenosis due to decreased afterload reduction.

Surgery/Anesthesia—If hypotension occurs during major surgery or anesthesia, and is considered due to the effects of captopril, it is correctable by volume expansion.

Drug Interactions: *Hypotension: Patients on Diuretic Therapy*—Precipitous reduction of blood pressure may occasionally occur within the 1st hour after administration of the initial captopril dose in patients on diuretics, especially those recently placed on diuretics, and those on severe dietary salt restriction or dialysis. This possibility can be minimized by either discontinuing the diuretic or increasing the salt intake about 1 week prior to initiation of captopril therapy or by initiating therapy with small doses (6.25 or 12.5 mg). Alternatively, provide medical supervision for at least 1 hour after the initial dose.

Agents Having Vasodilator Activity—In heart failure patients, vasodilators should be administered with caution.

Agents Causing Renin Release—Captopril's effect will be augmented by antihypertensive agents that cause renin release.

Agents Affecting Sympathetic Activity—The sympathetic nervous system may be especially important in supporting blood pressure in patients receiving captopril alone or with diuretics. Beta-adrenergic blocking drugs add some further antihypertensive effect to captopril, but the overall response is less than additive. Therefore, use agents affecting sympathetic activity (e.g., ganglionic blocking agents or adrenergic neuron blocking agents) with caution.

Agents Increasing Serum Potassium—Give potassium-sparing diuretics or potassium supplements only for documented hypokalemia, and then with caution, since they may lead to a significant increase of serum potassium. Use potassium-containing salt substitutes with caution.

Inhibitors of Endogenous Prostaglandin Synthesis—Indomethacin and other nonsteroidal anti-inflammatory agents may reduce the antihypertensive effect of captopril, especially in low renin hypertension.

Drug/Laboratory Test Interaction: Captopril may cause a false-positive urine test for acetone.

Carcinogenesis, Mutagenesis and Impairment of Fertility: Two-year studies with doses of 50 to 1350 mg/kg/day in mice and rats failed to show any evidence of carcinogenic potential. Studies in rats have revealed no impairment of fertility.

Pregnancy: Category C—There are no adequate and well-controlled studies in pregnant women. Embryocidal effects and craniofacial malformations were observed in rabbits. Therefore, captopril should be used during pregnancy, or for patients likely to become pregnant, only if the potential benefit outweighs the potential risk to the fetus. Captopril crosses the human placenta.

Nursing Mothers: Captopril is secreted in human milk. Exercise caution when administering captopril to a nursing woman, and, in general, nursing should be interrupted.

Pediatric Use: Safety and effectiveness in children have not been established although there is limited experience with use of captopril in children from 2 months to 15 years of age. Dosage, on a weight basis, was comparable to that used in adults. Captopril should be used in children only if other measures for controlling blood pressure have not been effective.

ADVERSE REACTIONS: Reported incidences are based on clinical trials involving approximately 7000 patients.

Renal—About 1 of 100 patients developed proteinuria (see WARNINGS). Renal insufficiency, renal failure, polyuria, oliguria, and urinary frequency in 1 to 2 of 1000 patients.

Hematologic—Neutropenia/agranulocytosis have occurred (see WARNINGS). Anemia, thrombocytopenia, and pancytopenia have been reported.

Dermatologic—Rash (usually maculopapular, rarely urticarial), often with pruritus and sometimes with fever and eosinophilia, in about 4 to 7 of 100 patients (depending on renal status and dose), usually during the 1st 4 weeks of therapy. Pruritus, without rash, in about 2 of 100 patients. A reversible associated pemphigoid-like lesion, and photosensitivity have also been reported. Angioedema of the face, mucous membranes of the mouth, or of the extremities in about 1 of 1000 patients—reversible on discontinuance of captopril therapy. One case of laryngeal edema reported. Flushing or pallor in 2 to 5 of 1000 patients.

Cardiovascular—Hypotension may occur, see WARNINGS and PRECAUTIONS (Drug Interactions) for discussion of hypotension on initiation of captopril therapy. Tachycardia, chest pain, and palpitations each in about 1 of 100 patients. Angina pectoris, myocardial infarction, Raynaud's syndrome, and congestive heart failure each in 2 to 3 of 1000 patients.

Dysgeusia—About 2 to 4 (depending on renal status and dose) of 100 patients developed a diminution or loss of taste perception; taste impairment is reversible and usually self-limited even with continued drug use (2 to 3 months). Gastric irritation, abdominal pain, nausea, vomiting, diarrhea, anorexia, constipation, aphthous ulcers, peptic ulcer, dizziness, headache, malaise, fatigue, insomnia, dry mouth, dyspnea, cough, alopecia, and paresthesias reported in about 0.5 to 2% of patients but did not appear at increased frequency compared to placebo or other treatments used in controlled trials.

Altered Laboratory Findings: Elevations of liver enzymes in a few patients although no causal relationship has been established. Rarely cholestatic jaundice and hepatocellular injury with or without secondary cholestasis, have been reported. A transient elevation of BUN and serum creatinine may occur, especially in volume-depleted or renovascular hypertensive patients. In instances of rapid reduction of longstanding or severely elevated blood pressure, the glomerular filtration rate may decrease transiently, also resulting in transient rises in serum creatinine and BUN. Small increases in serum potassium concentration frequently occur, especially in patients with renal impairment (see PRECAUTIONS).

OVERDOSAGE: Primary concern is correction of hypotension. Volume expansion with an I.V. infusion of normal saline is the treatment of choice for restoration of blood pressure. Captopril may be removed from the general circulation by hemodialysis.

DOSAGE AND ADMINISTRATION: CAPOTEN (captopril) should be taken one hour before meals. In hypertension, CAPOTEN may be dosed bid or tid. Dosage must be individualized; see DOSAGE AND ADMINISTRATION section of package insert for detailed information regarding dosage in hypertension and in heart failure. Because CAPOTEN (captopril) is excreted primarily by the kidneys, dosage adjustments are recommended for patients with impaired renal function.

Consult package insert before prescribing CAPOTEN (captopril).

HOW SUPPLIED: Available in tablets of 12.5, 25, 50, and 100 mg in bottles of 100 (25 mg also available in bottles of 1000), and in UNIMATIC® single dose packs of 100 tablets. (J3-658D)

Reference: 1. Cannon PJ, Criley JM, Dzau VJ, et al: A placebo-controlled trial of captopril in refractory chronic congestive heart failure. J Am Col Cardiol 2:755–763, 1983.

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Pension Plan Management

How to Turn A Pension Plan Into A Profit Center

(This article is the first in the series of articles dealing with Value-Added Pension Plan Management)

Isn't it time for Pension Plans to find out whether their money managers' investment performance really help acheive the plans' actuarial goals?

A pension plan is a financial asset. If businesses considered their pension plans a "profit center" more attention would be directed toward effective pension plan management. Frequently, the pension plan has assets which approach or even exceed the asset base of the business itself. Yet pension plans rarely receive scrutiny or intensity of management commensurate with their value.

Successful pension plan management requires:

1. Evaluation of long-term financial objectives.
2. Allocation of assets into investment categories.
3. Determination of the scope and aggressiveness of the investments.
4. Selection of money managers able to meet the plan's financial objectives.
5. Evaluation and monitoring of the investment performance.

Most small pension plans ($200,000—$2,000,000) consider the first four steps using the advice of actuaries and friends. How many have thought of the fifth step? A realistic assessment of how investment managers operate over a series of changing investment environments is a critical requirement for pension plan management, both for control of risk and for future success in achieving targeted returns.

The dominant motive for establishing and maintaining a pension plan is pension guarantee in the future. The size of additional contributions to the plan depends on the general cash flow situation. In order to tax shelter your present income, the size of the contributions in maximum allowable though it may not be enough to match your future liabilities. In this case, investment income becomes very important: it provides an additional tax-deferred source of money. If there is a cash flow problem or other considerations prevent you from making additional contributions, you need a money manager who is producing enough investment income to self fund your pension plan. Regardless of the situation, reaching the targeted returns is paramount in achieving a self funding pension portfolio which can reduce or eliminate continued pension contributions. If, by now, you recognized the effect investment perfomance makes on your pension plan investment, it should have become clear how critical performance evaluation and monitoring is.

How many times have you asked a question, "How well is my pension plan doing?" Does your money manager provide the information necessary to answer this question? If he does, do you know how to evaluate and monitor this information? Has a standard for investment performance been agreed upon between you and your money manager? If yes, are you confident this standard is appropriate? How do you differentiate between successful and unsuccessful money mangers?

These questions would probably evoke a wide range of opinion. The health of your pension plan depends upon a continuous process of evaluation and monitoring of investment perfomance. The next article in the series will discuss different performance standards, and what to keep in mind when selecting one for your pension plan.

by Tatayna Okshteyn

Tatyana Okshteyn is associated with "Aetna Capital Management" in Hartford, and is a consultant to "Investment Evaluation Group, Inc." in Springfield, Mass. Mrs. Okshteyn holds an MBA from University of Massachusetts in Amherst and is a member of "Options and Futures Society of the United States."

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Fall Dinner Meeting Highlights

Our fall dinner meeting at Chez Josef was attended by a gathering of 318 M.D.'s, spouses, and friends, the largest gathering in recent memory. This enthusiastic group was treated to an excellent evening which included a roast beef dinner, awards presentations, and our guest speaker, nationally syndicated columnist, Mark Shields.

Prior to dinner, Representative Iris Holland and Senator John Burke were given awards for "Legislator of the Year" for their work in their respective legislative bodies. In addition, Mayor Richard Neal was honored in recognition of the City of Springfield's 350th Anniversary.

Immediately following dinner Mark Shields, a columnist and T.V. commentator, presented us with "The Wit and Wisdon of Mark Shields". Mr. Shield's comments and wit were aimed entirely at the political process of choosing a President of the United States of America. After a variety of political jokes aimed at a bipartisan group of politians, Mr. Shield's began in earnest by telling is that the presidential politics of 1986—1988 should be very interesting. Politics in the U.S.A. are characterized by two things: optimism and a belief in change. But, change occurs slowly. From 1860 to 1932 —Lincoln through Hoover— the Republican Party was dominant. Only two Democrats were elected to the White House in those 72 years. In that Republican span they outlawed slavery, saved the Union, settled the West and industrialized the nation. During that period the Democrats were primarily the party of southern unreconstructed Civil War veterans and big city machines, according to Mr. Shields.

However, starting in 1932, the Democrats dominated the White House. Only Dwight Eisenhower broke that spell and President Eisenhower did not know to which party he belonged 12 months before he was elected. During the Democratic era the role of federal government changed and became more active and affirmative. Government was seen to provide a sense of economic security to its citizens. Our country changed from a relatively weak and isolationist nation to the most powerful nation in the world in a period of 12 years.

But, the Democrats were replaced and the course of the United States of America was changed by the Republicans under Ronald Reagan. The Republicans represented a party of change and of optimism. The grounds of the political debate were identified in 1980 by the Republicans, e.g. the excessive role the federal government plays in our lives.

Mr. Shields went on to explain that when the party in power becomes the party out of power its reponse goes through four stages. First stage--the losing party blames its candidate, such as Hoover or Carter. Second stage--it disparages the leader of the party that beats them (Roosevelt was a bird-brain. Ronald Reagan could clean both ears with one long continuous Q-tip). Four years later the party comes back and nominates "one of its own", such as Alf Landen or Walter Mondale. Third Stage--the party that loses decides there must be some gimmick they are using to beat us--(Roosevelt was good on radio; or Reagan is good on T.V.) Fourth stage--let's find a hero to lead us, the Republicans find Eisenhower. But although Eishenhower won, the Democrats were really still in power and we had the social legislation such as Medicare and Medicaid. Not until Ronald Reagan became President did the rules of the game change and the talk of new social programs came to an abrupt halt; the debate centered around which programs to cut.

Ronald Reagan stands out from other recent Presidents in his leadership abilities. Mr. Reagan has in particular two characteristics that set him apart: the first is a total lack of self pity, most of our recent Presidents have spent the better part of their careers scheming and planning on how to get to the White House only once there to tell us what a terrible job it was--Ronald Reagan relishes it. Second, Mr. Reagan's goal is not merely to hold Presidential power for its own sake, but to promote his philosophy of government. The Presidency is merely a tool.

Who will be our next President? Mr. Shields does not pretend to know. But, in studying the trends of our politics he points out the following:

1. Americans are more conservative.
2. They look for a President who is not a professional politician.
3. A President who will be philisophically conservative, but operationally liberal.

The next President will embody these principles along with a belief in change. If all this seems rather dry, its because you weren't there to appreciate the humor and the delivery with which these insights were presented to us.

Terry D. Ryan, M.D.

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January 12, 1987	Diabetic Foot	Dr. David Campbell
February 9, 1987	Renal Lithotripsy	Dr. Pablo Gomery

Time: 7:30 p.m. CME Credit: 2 Hours category I Springfield Academy of Medicine

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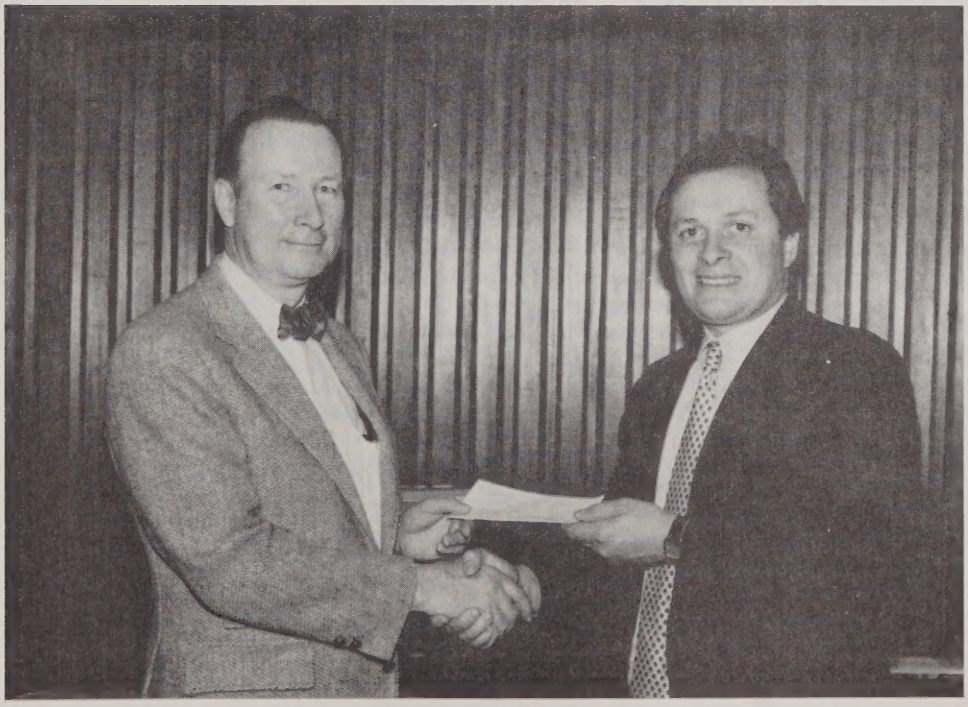

Dr. James G. Fitzpatrick, (left) Chairman of the Physicians Portrait Fund 1986 Committee, accepts a donation of $1,000 from Mr. Henry Holbrook, Branch Manager of the East Windsor Connecticut Division of the Contel Computer Systems Corporation.

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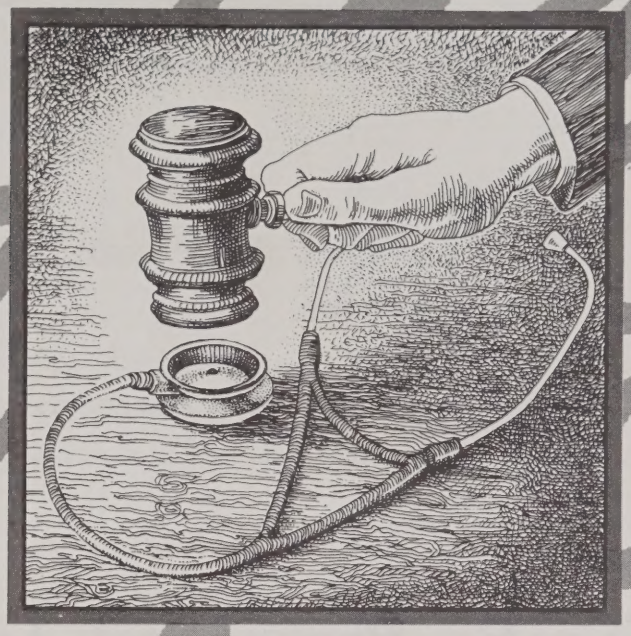

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Welcome New Members

Lydia J. Sarro, M.D.
444 Montgomery Street
Chicopee, MA 01020

BORN:	January 16, 1958
PREMED:	Northwestern University IL 1975-79
MEDICAL:	Northwestern University School of Medicine 1977-81
INTERNSHIP:	University of Connecticut 1981-82
RESIDENCY:	University of Connecticut 1982-84
FELLOWSHIP:	Children's Hospital Boston 1984-86
SPECIALTY:	DEVELOPMENTAL PEDIATRICS

Armand A. Aliotta, M.D.
75 Springfield Road
Westfield, MA 01085

BORN:	March 7, 1952
PREMED:	University of Dayton, Ohio 1970-74
MEDICAL:	University of Pavia, Italy 1974-80
INTERNSHIP:	University of Medicine, Newark, New Jersey, 1981-82
RESIDENCY:	University of Medicine, Newark, New Jersey, 1982-85
SPECIALTY:	NEUROLOGY

Daniel P. George, M.D.
444 Montgomery Street
Chicopee, MA 01020

BORN:	December 7, 1956
PREMED:	Wesleyan University, CT 1974-78
MEDICAL:	University of Connecticut, Farmington 1978-82
INTERNSHIP:	Medical University of South Carolina 1982-83
RESIDENCY:	Medical University of South Carolina 1983-85
SPECIALTY:	INTERNAL MEDICINE

David R. Kelley, M.D.
1221 Main Street
Holyoke, MA 01040

BORN:	August 16, 1952
PREMED:	St. John Fisher College, New York 1970-74
MEDICAL:	Howard University College of Medicine 1976-80
INTERNSHIP:	Barnes Hospital, St. Louis, MO 1980-81
RESIDENCY:	Barnes Hospital, St. Louis, MO 1981-86
SPECIALTY:	UROLOGY

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Welcome New Members

continued from previous page

Timothy L. Hainds, M.D.
759 Chestnut Street
Springfield, MA 01107
BORN: March 18, 1959
PREMED: University of Iowa 1979-82
MEDICAL: Southern Illinois University 1982-86
INTERNSHIP: Baystate Medical Center, July/1986 to present time
SPECIALTY: ANESTHESIA
RESIDENT

Jane Ellen Boyd, M.D.
759 Chestnut Street
Springfield, MA 01107
BORN: July 9, 1958
PREMED: Vanderbilt University Nashville, Tennessee 1976-80
MEDICAL: University of Cincinnati 1982-86
INTERNSHIP: Baystate Medical Center 1986-present time

Mary P. Tierney, M.D.
759 Chestnut Street
Springfield, MA 01107
BORN: October 11, 1953
PREMED: University of Notre Dame, 1976-80
MEDICAL: Loyola-Stritch School of Medicine, Maywood, Illinois 1982-86
INTERNSHIP: Baystate Medical Center 1986-87

Ruth G. Crump, M.D.
759 Chestnut Street
Springfield, MA 01107
BORN: October 8, 1953
PREMED: University of California 1975-81
University of Houston 1972-75
MEDICAL: University of California 1981-86
INTERNSHIP: Baystate Medical Center 7/86-present time

Nancy Ann Johnson, M.D.
759 Chestnut Street
Springfield, MA 01107
RESIDENT
BORN: August 29, 1959
PREMED: Willamette University Salem, Oregon 1977-81
MEDICAL: Oregon Health Science University, Portland, Oregon 1981-85
INTERNSHIP: BMC 1985-present time
SPECIALTY: OB/GYN

Kevin Novak, M.D.
759 Chestnut Street
Springfield, MA 01107
BORN: April 25, 1952
PREMED: Carleton College, Minnesota 1970-75
MEDICAL: University of Minnesota, Minneapolis 1982-86
INTERNSHIP: BMC July/1986-present time

Lauren Proctor, M.D.
444 Montgomery Street
Chicopee, MA 01020
BORN: November 24, 1955
PREMED: University of Chicago 1972-76
INTERNSHIP: Yale-New Haven Hospital 1981-82
RESIDENCY: Yale New-Haven Hospital 1982-85
SPECIALTY: OB/GYN

Gerald Ingram, M.D.
444 Montgomery Street
Chicopee, MA 01020
BORN: October 25, 1937
PREMED: University of Melbourne, Australia 1954-56
MEDICAL: University of Melbourne, Australia 1957-62
INTERNSHIP: St. Vincent's Hospital 1963-64
RESIDENCY: St. Vincent's Hospital 1983-86
SPECIALTY: INTERNAL MEDICINE/ DERMATOLOGY

Robert Lout, M.D.
1221 Main Street
Holyoke, MA 01040
BORN: September 8, 1946
PREMED: St. Anselm's College, New Hampshire 1964-68
MEDICAL: Georgetown University 1969-73
INTERNSHIP: St. Elizabeth's Hospital 1973-74
RESIDENCY: St. Elizabeth's Hospital 1974-75
U. Mass. Medical Center 1977-78
SPECIALTY: PREVENTIVE & CARDIAC REHABILITATION

Kathleen A. Cassin
120 Maple Street
Springfield, MA 01103
BORN: August 3, 1986
PREMED: Providence College, Providence, RI 1974-78
MEDICAL: Brown University 1978-82
INTERNSHIP: Baystate Medical Center 1982-83
RESIDENCY: Baystate Medical Center 1983-86
SPECIALTY: OB/GYN

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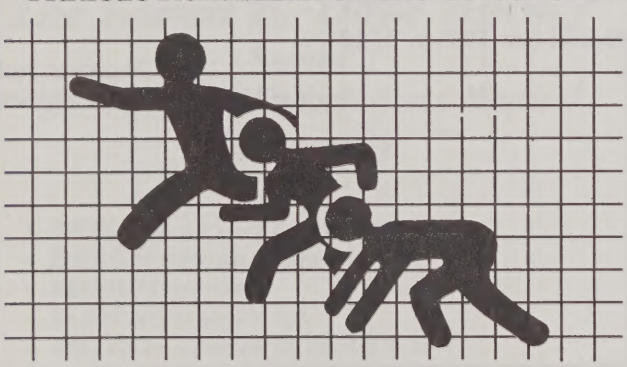

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Door-To-Door Lead Screening

The Visiting Nurse Association of Springfield

(Lead Poisioning Prevention Program-L.P.P.P.)

In July 1984, the Visiting Nurse Association of Springfield (V.N.A.S.) was granted a special contract by the Massachusetts State Department of Public Health to provide lead poisioning screening and case management services to children between the ages of nine months and six years living in the City of Springfield. Since that time, two registered nurses have been making home visits to children at risk of lead poisioning. The visits include an environmental and nutritional assessment as well as a general health and nutritional evaluation. A discussion about the potential sources of lead poisioning, its detection and treatment are also an important part of the visit. In addition, the nurses may refer families to other agencies such as the Women, Infants, and Children Program, (W.I.C.), the Expanded Food and Nutrition Education Program, (E.F.N.E.P.), or the Department of Social Services, (D.S.S.), if the need is apparent.

Paula Niejadlik and Maddy Anderson, the two professionals appointed to the program in 1984, work closely with local pediatricians, clinics and area hospitals in an all out effort to eradicate this preventable disease. Both nurses are active participants in the New England Childhood Lead Poisioning Program task force, (N.E.C.L.P.P.), and have helped to develop treatment brochures and other literature that serve as excellant vehicles for delivering lead information and increasing public awareness. Paula and Maddy also provide routine inservice education to community agencies as well as providing major presentations to organizations such as the National Association for Home Care, (N.A.H.C.). As an example, in September 1986, both women presented a workshop for N.A.H.C. in New Orleans, Louisiana entitled, "Combating Lead—A Community Program".

Fixed site screening at the Head Start Day Cares and the Homer Street Infant-Toddler Program are a regular part of the Lead Poisoning Prevention Program. The team also participates in any public service program that will help them access their target population. Springfield's offering earlier this year, WELLNESS WEEK, is a good illistration of this. With the assistance of Agency para-professionals, Paula and Maddy also provide intensive door-to-door screening in high risk areas during the summer months.

Every year in Massachusetts over fifteen hundred children under six are identified as lead poisoned. More go undetected and untreated. Because the early signs of lead poisoning are easily mistaken for other health problems, blood screening is crucial to the early detection of this dangerous and debilitating disease. MOST IMPORTANTLY, the efforts of the V.N.A.S. can only be effective if the medical community works together. None should ever forget that this disease that causes irreversible health damage and learning deficits is MAN-MADE.

Please call the V.N.A.S. at 781-5070 for further information.

Diane Gonyea, R.N.

Notes & Quotes of Interest

EYE CARE HELPLINE RECEIVES 100,000th CALL: The toll-free Helpline that provides medical eye care for older Americans—1-800-222-EYES—has received more than 100,000 calls from across the U.S. since it opened Jan. 6.

Emerson H. Hillyard, 66, of Ulysses, PA, was the 100,000th person to call the National Eye Care Project, a public service program cosponsored by the Foundation of the American Academy of Ophthalmology and the Massachusetts Society of Eye Physicians and Surgeons.

Mr. Hillyard has been referred to a nearby volunteer ophthalmologist, who will provide a medical eye exam and treatment of any existing medical eye conditions at no out-of-pocket cost to him.

"Through this outreach effort," said George B. Citron, MD, President of the Massachusetts Society of Eye Physicians and Surgeons, "we are providing medical eye care for older people whose sight is threatened by diseases like macular degeneration, cataracts and diabetic retinopathy. We want to let people know that deteriorating eyesight in their later years can be prevented."

The National Eye Care Project provides medical eye care to U.S. citizens and legal residents age 65 and over who are not currently under the care of an opthalmologist, who have no access to one, or who have not seen one in the past three years.

A total of 967 Massachusetts residents have called the service, and 581 have been referred to volunteer ophthalmologists near their homes. The matching of patients to physicians is done by a computer, which then generates a letter informing the patient to call the physician for an appointment.

Of the 100,000 callers, 66,200 have been referred to physicians for medical eye care. More than 16,000 have already been treated for sight-threatening eye diseases. Thirty-four percent of these patient had NEVER had an eye exam until they called the Helpline.

Patients who do not have Medicare or other insurance will receive care at no charge. For those who have coverage, participating ophthamologists will accept insurance as payment in full for their services, without billing copayments or deductibles. Cost of hospital care, eyeglasses, and prescription drugs is not covered.

The National Eye Care Project Helpline is open weekdays from 8 am to 5 pm in all time zones except Hawaii (8 am to 3 pm). The service opened in Washington state Jan. 6, and was gradually implemented by region, becoming available July 22 in all states.

PHYSICIAN FOUND NEGLIGENT FOR NOT USING THE MEDICAL LIBRARY: Not developing and maintaining an ongoing relationship with your local medical librarian can be hazardous to your medical practice.

Within the past three years Supreme Courts in four states, California, New Jersey, West Virginia and Washington, have ruled in favor of the plaintiff in "wrongful life" lawsuits. Wrongful Life suits refer to the responsibility of the physician to inform the pregnant patient of the risks of hereditary defects that might be present in her case.

In 1983, the Supreme Court in the state of Washington in the Harbeson vs. Parke-Davis case contended that *"'none of the doctors conducted literature searches or consulted other sources for specific information regarding the correlation betwen Dilantin and birth defects.'"**

Keep abreast of the times, phone your librarian who can now offer Medline searches in order to protect your future. Hours are 9 to 4, Monday thru Friday.

*Medical Law 1985 v. 4; 189-94

Margaret Stoler
Springfield Academy of Medicine

VNA.
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In Memoriam

KAREL SUSAT—SURGEON, LEADER, AND CHAMPION OF FREEDOM

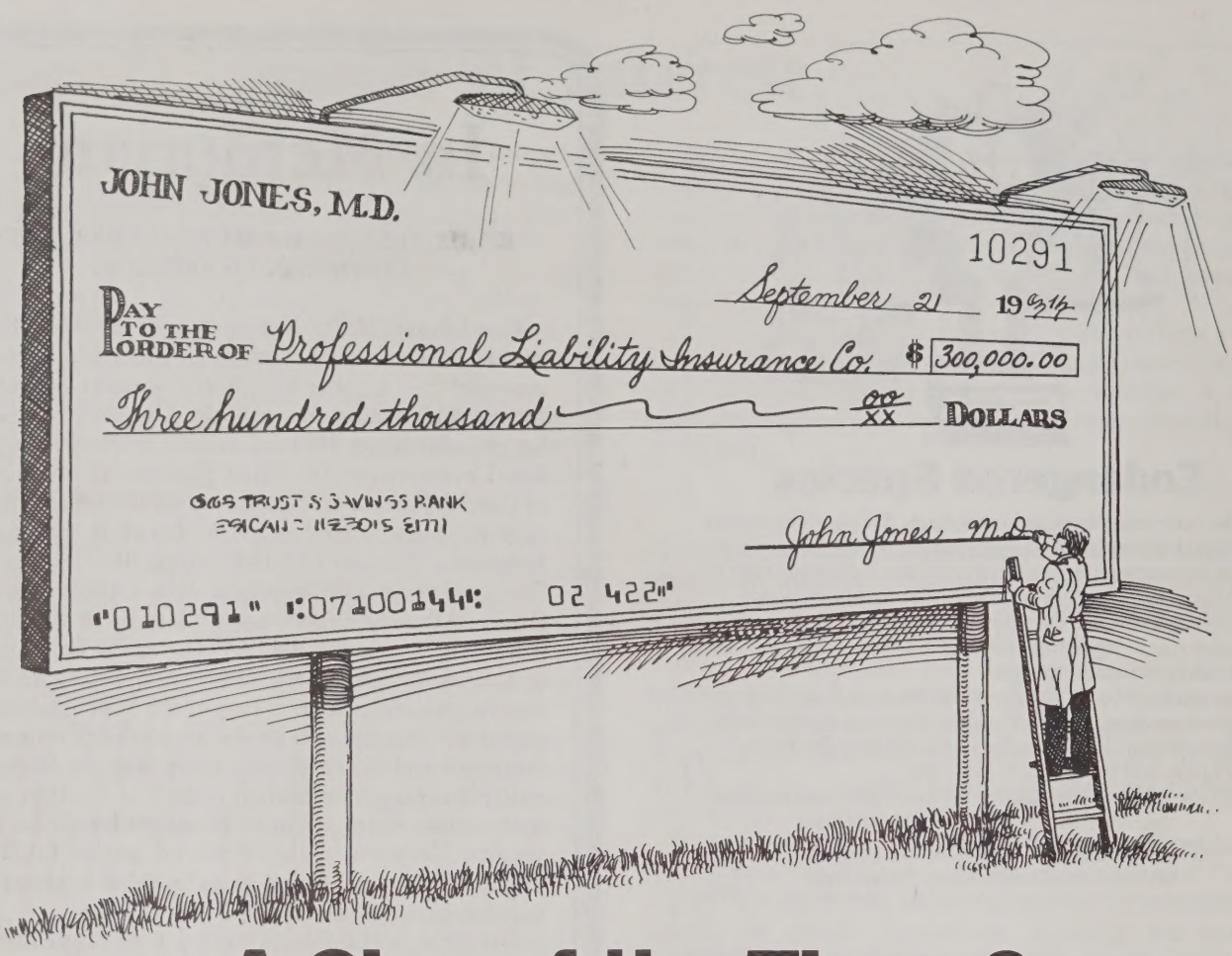
Karel Susat, M.D. died on Monday, July 7, 1986; he was 70. Dr. Susat was raised in Czechoslovakia. He attended the Charles University Medical School in Prague and during the war, the University of Edinburgh in Scotland. He received his doctorate from Oxford University in 1939. After the German occupation of Czechoslovakia in 1938 he joined the underground movement and served as courier between Prague and Belgrade. Threatened with arrest he joined the Foreign Legion and later the Free Czech Army in France. After the fall of France he served in the British Royal Air Force until 1945. After the war he returned to Czechoslovakia: when the Communist Regime took over he was declared an enemy of the State. He was arrested and interrogated by the Secret Police on several occasions and realized that there was no hope for either his country or himself to be free. In 1951 after seven unsuccessful attempts he escaped with his wife via East Germany to the West and landed finally in England. There he served as a clinical assistant at the London University Hospital.

He came to the United States in 1952 spending a year in Glen Cove, New York after which he came to Holyoke. He practiced in Holyoke from 1953 until his death. He was originally the senior surgeon at the Holyoke Soldier's Home. After 1956, he was in the private practice of surgery.

Dr. Susat was active in hospital and medical society affairs throughout his career. He was a Councilor for the HDMS for several years. He was chief of surgery at both the Providence and Holyoke Hospitals. He was chief of staff at the Holyoke Hospital and served as a Director of that institution for many years.

Having lived through the takeover of medicine by governments in two countries, Dr. Susat was deeply concerened about events here during the past several years. He had a rare ability to articulate his interpretation of health care issues and because of this was deeply respected by physicians, hospital administrations and trustees. In his various roles of leadership, he was blunt, fair and firm. He never balked at taking on difficult or unpleasant assignments.

Dr. Susat's hobbies were photography and bridge; he was expert at both. He and his wife Jana traveled widely. They always brought back beautiful photographic records of their travels throughout the world. He will be deeply missed by patients, colleagues and friends.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In 1983, 22 physician-owned professional liability insurance companies were forced to raise their premiums an average of 17 percent. At that rate, high-risk insurance coverage that cost $63,000 in 1983 could top $300,000 in just ten years.

These costs are leading to an affordability crisis which affects everyone. Physicians are concerned about rising premiums, exorbitant awards and continued insurance availability. Patients pay the price in increased costs and limited access to care.

Liability problems exact a high toll on physicians—in time and money, and even on their health. Some have been forced into early retirement; others have modified their practices to avoid high-risk procedures.

There is help. The American Medical Association's Special Task Force on Professional Liability and Insurance has developed an ambitious plan of action to respond to the crisis. This includes reviewing tort reform, working with the nation's policymakers to address the issue, promoting state coalitions to deal with the problem, distributing patient information materials and instructing physicians on how to avoid lawsuits.

If you want something done about the professional liability problem, become part of the solution: join the AMA.

For more information about membership, call toll-free 800/621-8335 (in Illinois, call collect 312/645-4783), or return this coupon to:

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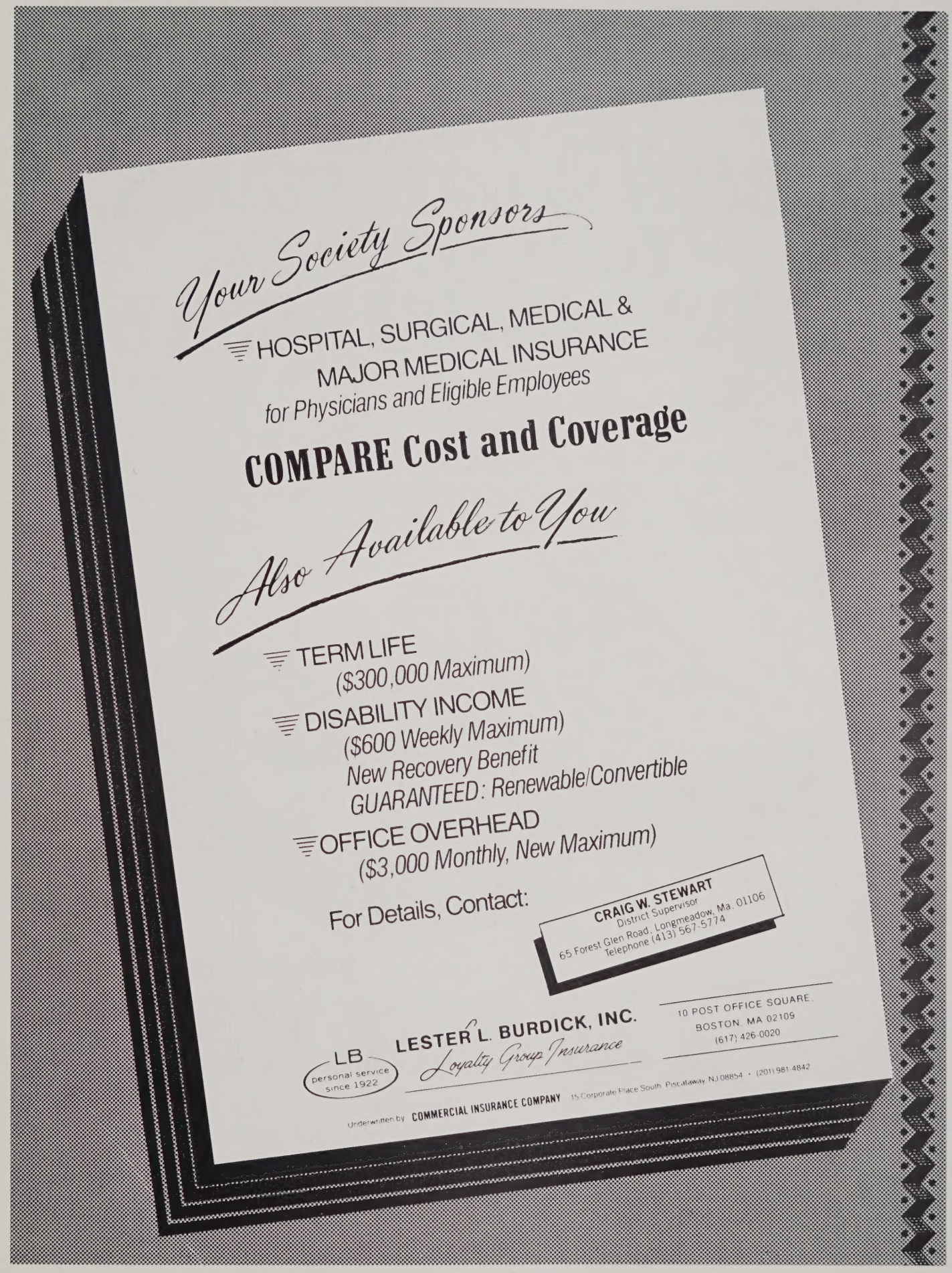
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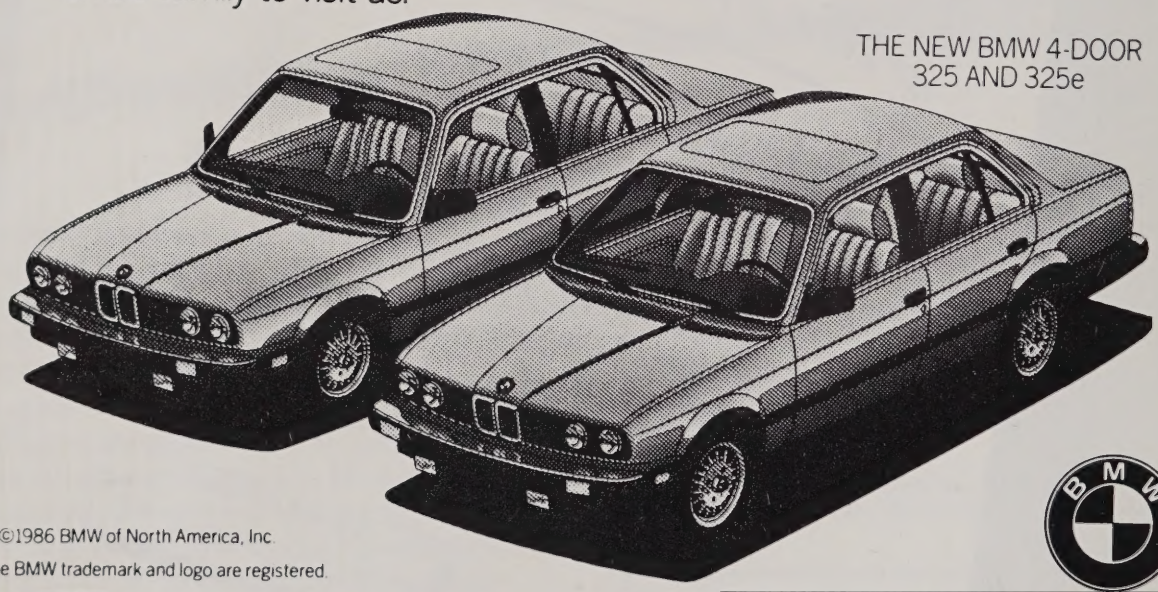

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